**ASSAM NURSES' MIDWIVES' & HEALTH VISITORS' COUNCIL**
**SIX MILE, KHANAPARA, GUWAHATI-22**

# TA/DA CLAIM FORM

Name :-

Designation :-

Purpose of Journey :-

Date of Journey :- On _____from_____ to _____

Return Journey on :- On _____from_____ to _____

A) D.A. No. of Days _____ @ _____ ₹ _____

(Approved Tour Diary must be enclosed herewith for settle of Bill)

B) Traveling Expenses:

i) Mode of Journey by _____ ₹ _____
(Train/Bus, ticket must be submitted)

Others_____ ₹ _____

C) Honorarium for Inspection, School/College_____ ₹ _____

Total claim amount ₹ _____

Claimants' Signature

---

## Office Use Only

i) D.A. @ _____x No. of Days _____ ₹ _____

ii) Traveling Expenses: ₹ _____

iii) Others ₹ _____

Total Bill amount ₹ _____

Net Payable ₹ _____

Registrar

---

## Money Receipt

Received with thanks a from Registrar, Assam Nurses Midwives' & Health Visitors Council a sum of ₹ _____/- ( Rupees _____
_____) only as TA/DA.

Date: Recipient Signature